published as reports in the HTA monograph series. The main objective of the HTA programme is the diffusion of state of the art evidence without any mandatory role regarding guidelines implementation or rationing in health care. The HTA programme also provides support for the work of the National Institute for Health and Clinical Excellence (NICE), a governmental independent organisation with a more prominent role in priority setting. The HTA programme is the interface between NICE and the review groups contracted to produce the technology assessment reports. All guidelines are published with the expectation that they will be reviewed and updated when new and relevant evidence is made available. Both the HTA programme and NICE are tax-revenue funded, you can find more about these organisations in their websites (http://www.publichealth.nice.org.uk, http://www.hta.nhsweb.nhs.uk/).

Regarding Dr. Hudorović's concern about the comparability of the patients undergoing MRCP and ERCP, although only the best of the available evidence was considered by the review team, the quality of the studies was established as moderate and it was difficult to ascertain whether an appropriate spectrum of patients was included. A systematic review was conducted by the systematic reviewers team of the ScHARR Technology Assessment Group (University of Sheffield, http://www.sheffield.ac.uk/scharr/sections/heds/collaborations/scharr-tag), with a total of 28 prospective diagnostic studies selected and assessed using quality criteria. Only those studies where the included patients had both diagnostic tests, and that obtained MRCP efficacy against final diagnosis (on the basis of surgical findings, percutaneous biopsy, clinical follow-up and others) were used to inform the sensitivity and specificity parameters in the model. More detail on the studies is provided in the HTA monograph referenced in the paper.

Dr. Hudorović also seems to suggest that our results could be questionable in the sense that ''*an improvement of quality of life is dependent of the pre-procedural base case values and independent of the pre-operative co-morbidities*''. Following conventional practice, utility values for the different health states were obtained from the Harvard CUA database, using the states of perfect health and death as anchor values in order to estimate the disutilities that would inform the model. The impact of co-morbidities in quality of life was not considered as this was out of the scope of our project. The publishing of the HTA monograph involves rigorous peer review by experts in different fields (clinicians, statisticians, modellers, health economists) so in case of a potential methodological pitfall this would have been noted and corrected before publication.

Finally, Dr. Hudorović points that the decision to perform MRCP or ERCP should take into account the operative risk. Just to remind the reader that the risk of death derived from a diagnostic ERCP and also the probability of overall complications were explicitly incorporated in the probabilistic model, although, of course, patient choice is a separate matter and should always be taken into consideration before taking a decision.

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Surgical issues in early management of atrial fibrillation in general surgical in-patients

Dear Editor,

In the article by Walsh et al.[1] the authors dealing with the management of non-cardiac surgical patients who developed new-onset atrial fibrillation (AF) during their in-patient stay. They stated that thorough clinical evaluations are recommended. Minimum evaluation of the patient with AF includes characterizing the pattern of the arrhythmia as paroxysmal or persistent, determining its cause, and defining associated cardiac and extracardiac factors. Additional investigation may include Holter monitoring and exercise testing, transesophageal echocardiography, and/or electrophysiological study.

In patients with persistent AF, there are fundamentally two ways to manage the dysrhythmia: to restore and maintain sinus rhythm or to allow AF to continue and ensure that the ventricular rate is controlled.

In my opinion, it could be interesting to state something about surgical issues in the management of patients with AF which is related to the arrhythmia itself and to the prevention of thromboembolism. Methods for nonpharmacological (surgical) corrections to maintain sinus rhythms if drug failure occurs including surgical ablation based on mapping studies of animal and human AF, Cox developed a surgical procedure (maze operation) which involves encircling the pulmonary veins by surgical incisions within the LA and radial incisions in both atria that join the mitral and tricuspid valve annuli.

Several catheter ablation strategies have been designed to produce similar effects. The recognition that foci triggering AF often originate within the pulmonary veins, the superior vena cava, the RA and LA, and the coronary sinus ablation of these foci eliminates or reduces the frequency of AF. Although these procedures have produced promising results, they have not yet been widely applied. Suppression of AF by pacing as a primary therapy for prevention of AF has not been validated.

There has been an interest in internal atrial cardioverter/defibrillators of AF for the past 10 years. Attempts have been made to find shock waveforms that reduce the energy requirements for cardioversion,

making the shock tolerable to awake patients. Potential candidates are mainly those with infrequent episodes of poorly tolerated AF, but are also suitable for catheter ablation.

Cardiovascular care is rapidly moving toward new based technologies, and many cardiovascular surgeons are looking for ways to become involved. By observing the way in which new technology is being applied, the surgeon can become more comfortable with the clinical indications and infrastructure that are necessary to implement new treatment modalities into their own practice. Second, the surgeon should partner with someone in their own community who is already involved in the new procedure, even if it means collaborating with a cardiologist, or interventional radiologist.

New training paradigms in cardiovascular medicine and surgery could attract new resident applicants and lead to a new model for the delivery of cardiovascular health care. The future could not be brighter for those who are willing to adapt, innovate and conquer (like authors of previously mentioned manuscript) the challenges like our forefathers of surgery did many years ago.

Reference

1. Walsh SR, Thomas C, Manohar S, Coveney EC. Early management of atrial fibrillation in general surgical in-patients. *Int J of Surg* 2006;**4**(2):115—7.

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